BRACE YOURSELF

for a smile!

James P. Thompson, D.D.S., M.S.D.
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ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic insurance benefit, the following information is necessary:

Name of Patient ______________________ Date of Birth: ______________

Name of Insured: ______________________ Date of Birth: ______________

Address: ______________________

Social Security #: ______________________ Telephone: ______________

Employed by: ______________________

Address: ______________________

Insurance Company: ______________________ Sub/Mmbr #: ______________

Address of Insurance Company: ______________________

Insurance Company Telephone: ______________________

Is Patient covered under another dental plan? If so, please complete the following information:

Name of Insured: ______________________ Date of Birth: ______________

Address: ______________________

Social Security #: ______________________ Telephone: ______________

Employed by: ______________________

Address: ______________________

Insurance Company: ______________________ Sub/Mmbr #: ______________

Address of Insurance Company: ______________________

Insurance Company Telephone: ______________________

I hereby authorize release of any information relating to this claim.

Signature ______________________ Date ______________

I hereby authorize payment of insurance benefits directly to the above named orthodontist.

Signature ______________________ Date ______________

Please notify our office of any changes in your insurance policy as soon as possible.